

1 WHAT IS DECISIONAL MENTAL CAPACITY?

- Legal Definition NOT Clinical Definition
- Different legal definition in different jurisdictions (ie. different provinces, different countries)
- Assessment of capacity for treatment refers to a LEGAL assessment NOT a clinical assessment
- Not tested by the Mini-Mental Status Test (MMSE)
- Clinical assessments underlie diagnosis, treatment recommendations and identify or mobilize social supports
- Legal assessments remove from the person the RIGHT to make autonomous decisions in specified areas
- Legal Assessments look at Decisional Ability to make a Particular decision (ie Capacity in respect to particular treatment, Capacity to handle property, Capacity in Respect to admission to long-term care, Capacity to make personal care decisions about shelter)

(credit to workshop slide by Dr. Janet Munson)

2 LEGAL DEFINITION OF CAPACITY IN RESPECT TO TREATMENT, ADMISSION TO CARE FACILITIES, AND PERSONAL ASSISTANCE SERVICES

Health Care Consent Act s.4

Two step definition

1. Able to understand the information that is relevant to making a decision about the treatment, admission, or personal assistance service as the case may be, and
2. Able to appreciate the reasonably foreseeable consequences of a decision or lack of decision

3 PRESUMPTION OF DECISIONAL CAPACITY

HCCA s.4

Person presumed to be capable for treatment, admission to care facilities and personal assistance services.

Exception

Person entitled to rely on presumption **UNLESS** he or she has reasonable grounds to believe the other person is incapable in respect to treatment, admission to care facilities, personal assistance services as case may be.

HCCA s.15

- May be capable in respect to some treatments and incapable in respect to others.
- May be incapable with respect to treatment at one time and capable at another

4 ASSESSMENT OF DECISIONAL CAPACITY *

Need to assess:

1. Ability to Understand (factual knowledge + problem solving ability)
2. Ability to Appreciate (realistic appraisal of outcome + justification of choice)

Understand - 1st Base

- Factual knowledge: preservation of old skills & knowledge
- Has the person had learning opportunities to acquire the relevant facts:
- Updated information re: medical status, new risks or limits in ADL functions?
- Does the person understand what treatment is being offered - what it is, benefits of it, risks,

Understanding Options - 2nd Base

- Able to comprehend information about options, risks to make an informed choice
- Able to attend to relevant stimuli, understand at conceptual level and retain essential information long enough to reach a decision
- Able to remember prior choices and express them in a predictable and consistent manner over time
- Able to problem solve around personal issues-probe specific examples

Appreciate - 3rd Base

- Able to appraise potential outcomes of a decision
- Focus on reasoning process, explore the personal weights, values attached to each outcome
- Acknowledges personal limitations/show insight
- Decision-making is reality-based, not being affected by delusions (fixed false beliefs) or skewed by emotional states (depression, hopelessness causing an undervaluing of survival issues).

Appreciate - 4th Base

Justification of choice:

- Shows evidence of rational (based in reality) manipulation of information - a "reasoned choice", not necessarily a reasonable choice
- Grounded in personal beliefs and values consistent with previous actions, expressed wishes, cultural or religious beliefs

(credit to workshop slides by Dr. Janet Munson)



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Tool on
**Capacity &
Consent**
Ontario edition

1 CONSENT TO TREATMENT REQUIRED

HCCA s.10

No treatment unless:

- a. Health Practitioner (HP) of opinion person CAPABLE in respect to treatment and person has consented, or
- b. HP of opinion that person INCAPABLE in respect to treatment and SDM gives consent.
- c. if Consent and Capacity Board or court finds person capable although HP was of opinion person not capable, HP shall not treat and shall ensure treatment not administered unless person gives consent.

2 WHAT IS VALID CONSENT?

HCCA s.11

- 1. must RELATE to TREATMENT
- 2. must be INFORMED (See box on INFORMED CONSENT)
- 3. must be given VOLUNTARILY
- 4. must not have been obtained through misrepresentation or fraud

3 WHAT IS INFORMED CONSENT?

HCCA s.11

Patient or SDM (if Patient incapable) received information about:

- 1. nature of treatment,
- 2. expected benefits of the treatment,
- 3. material risks of the treatment,
- 4. material side effects of the treatment,
- 5. alternative courses of action, and
- 6. likely consequences of not receiving treatment

PROVIDE the information about the proposed treatment in these categories that the reasonable person would require to make decisions. The Patient or SDM is also entitled to receive responses to any further questions that he or she may have about these matters.

4 WHAT IS CAPACITY FOR TREATMENT AND HOW DO YOU ASSESS THIS CAPACITY

See reverse

5 WHO ASSESSES CAPACITY IN RESPECT TO TREATMENT?

- the Health Practitioner offering the treatment (HCCA S.10)
- Capacity Assessors (as defined by the Substitute Decisions Act) DO NOT do this type of assessment

6 PROCESS FOR OBTAINING CONSENT TO TREATMENT CAPABLE PERSON

If HP of opinion that a person is capable in respect to the treatment offered,

- HP obtains informed consent - treats
- Patient refuses consent - HP not treat

7 PROCESS FOR OBTAINING CONSENT TO TREATMENT - INCAPABLE PERSON

HCCA S.18

- 1. HP of Opinion
- that person incapable re treatment proposed
- HP follows own College guidelines re: Rights information
- no application to CCB is made
- HP turns to SDM highest ranking in list for consent or refusal of consent

If HP informed

- 1. that person intends to apply or has applied to CCB for review of finding of incapacity , or
- 2. person intends to apply or has applied to CCB for appointment of representative or
- 3. another person intends to apply or has applied to the CCB to be appointed as representative

HP shall NOT treat and shall ensure treatment not begun:

- a. until 48 hours has elapsed since first informed on intended application to CCB and application not started
- b. until application to CCB withdrawn
- c. until CCB renders decision if none of the parties before CCB is informed of intention to appeal
- d. if HP advised of intention to appeal, until a period for commencing appeal has elapsed without an appeal being commenced (8 full days after Board hearing) or until appeal finally disposed of.

8 HIERARCHY OF SDMS WHO MAY GIVE OR REFUSE CONSENT - HCCA S.20

- 1. Guardian of person with authority for treatment.
- 2. Attorney in attorney for personal care with authority for treatment.
- 3. Representative appointed by CCB.
- 4. Spouse or partner.
- 5. Child or parent or Children's Aid Authority or other person lawfully entitled to give or refuse consent to treatment in place of parent - not include parent with right of access only - if CAS or person in place of parent, not include parent.
- 6. Parent with right of access only.
- 7. Brother or sister.
- 8. Any other relative.

If NO PERSON meets requirement then OPGT.

If CONFLICT between persons in same category and cannot agree and claim to be SDM above others OPGT shall act as SDM

9 RANKING - LIST OF SDMS IS A HIERARCHY

Person ranked lower on list may give consent only if no person higher meets requirements.

Exception - Family member present or contacted may consent if he or she believes :

- a. no person higher or in same paragraph exists OR
- b. if person higher exists, person is not guardian of person, POAPC, Board appointed representative with authority to consent and would not object to him or her making the decision.

10 REQUIREMENTS FOR SDM - HCCA S.20

SDM in list may give or refuse consent only if he or she is:

- 1. capable with respect to treatment,
- 2. 16 unless parent of incapable person,
- 3. no court order or separation agreement prohibiting access to incapable person or giving or refusing consent on his or her behalf,
- 4. is available, and
- 5. willing to assume responsibility of giving or refusing consent.

11 PRINCIPLES FOR GIVING OR REFUSING CONSENT

The SDM who gives or refuses consent to a treatment on an incapable person's behalf shall do so in accordance with the following principles:

- 1. If the incapable person expressed a wish relevant to the

treatment proposed while capable the SDM shall give or refuse consent in accordance with the wish.

- 2. if the SDM does doesn't know of any relevant wishes, or if it is impossible to comply with the wish, the SDM shall act in the incapable person's best interests

12 WHAT ARE BEST INTERESTS?

In determining Best interests the SDM shall consider,

- a. the values and beliefs that the incapable person held when capable that the SDM believes he or she would still act on if capable;
- b. any other wishes expressed by the incapable person with respect to the treatment that are not required to be followed (ie wishes expressed when incapable, wishes that are impossible to follow, wishes that are not directly relevant to the specific treatment decision)
- c. the following factors:
 - 1. Whether the treatment is likely to,
 - i. improve the incapable person's condition or well-being,
 - ii. prevent the incapable person's condition or well-being from deteriorating, or
 - iii. reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate.
 - 2. Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment.
 - 3. Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her.
 - 4. Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.